STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on June 9, 2023, it was determined that Valley View Haven Inc. was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0623 SS=B		F 0623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=B	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. The State Long-Term Care Ombudsman was notified about the transfers for residents 21, 43, 68 and 81. There is no evidence that any resident was affected by the deficient practice. Transfers and Discharges over that	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=B	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	last year will be reviewed to ensure that appropriate notification is made to the State Long Term Care Ombudsman Social Services and the Medical Secretary will be educated on the criteria on sending transfers and discharges to the State Long-Term Care Ombudsman. This audit will be completed monthly for 3 months. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=B	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=B	Continued from page 4 Based on clinical record review and staff interview, it was determined that the facility failed to notify the representative of the Office of the State Long-Term Care Ombudsman about resident transfers, for four of five residents reviewed for hospitalizations (Residents 21, 43, 68, and 81). Findings include: Nursing documentation for Resident 68 dated May 6, 2023, at 5:33 AM revealed the resident was transferred to the hospital with a high fever. Nursing documentation for Resident 81 dated March 21, 2023, at 3:58 PM revealed that the resident was transferred to the hospital after becoming unresponsive. Nursing documentation for Resident 21 dated March 18, 2023, at 3:46 PM revealed the resident's abdomen was rounded, firm, and distended. The physician ordered the resident to be sent to the hospital.	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=B	Continued from page 5 Nursing documentation for Resident 43 dated March 20, 2023, at 9:45 AM revealed the physician is recommending the resident be sent to the hospital for intravenous antibiotics and admission. Review of the facility census revealed that Resident 43 returned to the facility on March 23, 2023. Further clinical record review for Residents 21, 43, 68, and 81 revealed no evidence that the Office of the State Long-Term Care Ombudsman was notified as required about the transfers to the hospital. During an interview with the Nursing Home Administrator on June 8, 2023, at 9:30 AM it was confirmed that the Office of the State Long-Term Care Ombudsman was not notified about the transfers for the above residents. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 7 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Resident 75 suffered no ill effects from the administration of oxygen at 1L/minute via nasal. Her orders were clarified during survey to receive oxygen at 2L/minute via nasal cannula. Resident 19 suffered no ill effects from the improper storage of her oxygen tubing.	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 8	F 0695	Other residents who utilize routine oxygen will be evaluated to ensure that they are utilizing the correct liter flow according to physician order and that the nasal cannulas are properly stored when not in use. Nurses will be re-educated to ensure correct liter flow and proper storage of oxygen equipment when not in use. An audit of residents utilizing oxygen therapy will be completed monthly to ensure that they are receiving the appropriate liter flow and that oxygen equipment is properly stored when not in use. This audit will be completed for three months. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 9 Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to administer supplemental oxygen consistent with professional standards of practice for one of two residents reviewed (Resident 75) and failed to store supplemental oxygen equipment per professional standards of practice for one of two residents reviewed (Resident 19). Findings include: A review of the policy titled "Oxygen Administration," last reviewed without changes on May 22, 2023, revealed that when oxygen tubing is not in use, store the tubing in a plastic bag (with a zip-lock top that is obtained from the storage room). The policy further noted to place the bag containing the tubing on top of the machine, making sure the tubing does not drag on the floor. A review of the current physician orders for Resident 19 dated April 7, 2023, instructed staff to	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 10 apply oxygen at two liters per minute via nasal cannula (medical tubing with two nasal prongs used to deliver supplemental oxygen into the nose) at all times. Review of Resident 19's current care plan revealed that the resident receives supplemental oxygen related to the medical history. Observation of Resident 19's room on June 7, 2023, at 11:03 AM revealed the resident was out of the room. Nasal cannula tubing was observed attached to an oxygen concentrator (a medical device that concentrates oxygen from the ambient air). The remaining end of the tubing was observed in a partially open dresser drawer. The tubing was unbagged and unprotected from contamination. Observation of Resident 19 on June 8, 2023, at 10:30 AM revealed the resident was sitting at her bedside table and receiving oxygen via a nasal cannula. The resident's wheelchair was also present near the foot of the bed and had a second nasal	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 11 cannula attached to a portable oxygen unit. The second nasal cannula was draped across the back of the wheelchair, unbagged, and unprotected from contamination. A concurrent interview with Employee 7, nurse aide, revealed Employee 7 was unaware how the resident's extra nasal cannula should be stored and stated the LPNs (licensed practical nurses) oversee a resident's oxygen therapy. An interview with the Nursing Home Administrator on June 8, 2023, at 10:38 AM revealed the oxygen tubing should be placed in a protective bag when not in use. Observation of Resident 19's room on June 8, 2023, at 1:30 PM revealed the resident was out of the room. A nasal cannula was observed attached to an oxygen concentrator that was turned on. The remaining tubing was draped across the resident's bed. The tubing was unbagged and unprotected from contamination.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	**4702 E MAIN STREET BELLEVILLE, PA 17004**
STATE LICENSE NUMBER: **220402**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 12 The above information regarding Resident 19 was reviewed in a meeting on June 8, 2023, at 2:00 PM with the Nursing Home Administrator and Director of Nursing. Review of a physician's order for Resident 75 dated March 20, 2023, revealed the resident was to receive oxygen at one liter per minute via nasal cannula as needed with exertion, and the staff may titrate (the process of determining the amount of oxygen based on the blood oxygen saturation) the oxygen to keep the pulse oximetry (a device placed on a finger to monitor of a person's blood oxygen saturation) greater than 90%. The resident may be on room air (no oxygen) when at rest. Review of the oxygen saturation summary for Resident 75 revealed that the last pulse oximetry was measured on May 19, 2023, at 3:45 PM and determined to be 95% on oxygen. Observation of Resident 75 on June 6, 2023, at 12:50 PM revealed the resident was sitting in the	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 13 dining room eating lunch and had oxygen running at one liter per minute by way of nasal cannula. Clinical record review for Resident 75 revealed a pulmonary (relating to the lungs, organs for breathing) consultation under the miscellaneous section of the electronic medical record. Review of this attachment revealed a form entitled "Physician Progress Notes/Consultation Form from pulmonary that was not dated. Further review revealed two entries that indicated the resident did not need oxygen at rest and the resident needs to use a flutter device (a respiratory device to help people clear secretions from their lungs) four times daily, 10 puffs each time. This form was not a complete consultation. During a meeting with the Nursing Home Administrator and Director of Nursing on June 8, 2023, at 1:30 PM the surveyor requested the complete pulmonary consultation as it was not available in the electronic or paper medical record.	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 14 Review of the pulmonary consultation for Resident 75 dated March 16, 2023, indicated the resident had stable pulmonary nodules (a small mass on the lung), chronic mycobacterium avium intracellular (infection caused by a group of bacteria in the lungs), and chronic bronchitis/bronchiolitis (inflammation/infection of the large and small airways in the lungs). The pulmonary consultation recommended oxygen with ambulation and sleep at two liters per minute and oxygen was not needed at rest. During an interview with Employee 1 (infection preventionist) on June 9, 2023, at 8:50 AM the surveyor discussed that the pulmonary consultation was not present in Resident 75's medical record until asked for by the surveyor, and the oxygen rate as currently ordered at one liter per minute to keep the pulse oximetry above 90% did not reflect the pulmonary consultation. Resident 75 did not have her pulse oximetry measured since May 19, 2023. Nursing documentation for Resident 75 dated June	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 15 9, 2023, at 9:04 AM revealed that the nurse reviewed the oxygen order from pulmonology with the attending physician and the oxygen order was changed to two liters at all times and the resident preferred this rate. During a further interview with Employee 1, on June 9, 2023, at 9:20 AM it was confirmed that she discussed the consultation findings with the attending physician and confirmed that Resident 75 should be receiving oxygen at two liters per minute. 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0730 SS=D		F 0730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=D	Continued from page 16 483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Facility cannot retroactively correct the performance review that were delinquent. No residents were affected by the deficient practice. RN Supervisors will be educated on timely completion of performance reviews. A baseline audit was performed to	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=D	Continued from page 17	F 0730	identify delinquent education and competency for nurse aides. Those without evaluation/education will be completed. A monthly calendar was made to correspond with anniversary date to complete evaluations/education in the future. Monthly audits will be completed for 3 months. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=D	Continued from page 18 Based on staff interviews and review of facility documentation, it was determined that the facility failed to ensure that nurse aides received an annual performance review for two of three nurse aides reviewed (Employees 2 and 3). Findings Include: Review of the facility's list of active nurse aide staff revealed Employee 2 had a hire date of November 1, 2021. Employee 2 should have had an annual performance review by November 1, 2022. Employee 3 had a hire date of November 30, 2016. Employee 3 should have had an annual performance review by November 30, 2022. Requests to review Employees 2 and 3's performance reviews revealed no documented evidence that the facility completed the reviews at least once every 12 months. Interview with the Nursing Home Administrator on	F 0730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0730 SS=D	Continued from page 19 June 8, 2023, at 11:30 AM confirmed the above findings. 28 Pa. Code 201.19 Personnel policies and procedures	F 0730		
F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 20 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. The kitchen underwent a deep cleaning to correct all founded deficient practices. Ceiling tiles were replaced in the receiving area. Facility can not retroactively correct the low dish machine temps.	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 21	F 0812	Ecolabs vendor was on site day issues with temp and leak were identified. Ecolabs same day fixed machine and tested it with no leak and temps within range. No residents were affected by the deficient practice. Dietary staff will be educated on kitchen cleanliness and appropriate dish machine temps. Kitchen audits will occur weekly x 4 weeks. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 22 Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a safe and sanitary condition in the facility's main kitchen. Findings included: Initial tour of the facility's main kitchen on June 6, 2023, between 10:28 AM and 10:57 AM with Employee 5, Director of Dining Services, revealed the following: A large stain on the ceiling above a stainless-steel prep table holding various appliances. The prep table had a cobweb between the bottom shelf and one of the legs. A significant amount of debris on the floor along the wall of the walk-in freezer that included a discarded small ice cream container. A significant accumulation of a black colored	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 23 substance on a vent above the dishwasher that extended into the ceiling. An air conditioner in the dishwasher area had a significant accumulation of dust build-up on all vents and the surrounding perimeter of the air conditioner. A large black colored corner fan in the dishwasher area had a significant build-up of dust on the fan blades and guards. Brown colored stains were observed on the wall above the fire extinguisher in the dishwasher area. The window screens above the three-compartment sink had a significant build-up of dust and debris. The windowsill had an accumulation of dust and debris that included a large strand of hair. A rack that held what Employee 5 identified as "clean dishes" included four plastic organizers that held multiple cups. There was a significant accumulation of a flaking, unidentified substance on	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 24 the organizers. The rack also held multiple black trays that contained various types of dishes. There was an accumulation of dust and debris that included hairs in the bottom of the trays. A rack that held two plastic organizers that contained personal sized boxes of cereal had a build-up of a flaking, unidentified substance and dust on the organizers. The "receiving area" and dry goods storage area for the main kitchen had a significant build-up of dust on an air vent located in the ceiling. There were eight ceiling tiles with large, brown-colored stains. Employee 5 reported "a pipe broke a couple weeks ago." During operation of the dishwashing unit, a valve on the top of the dishwasher expelled a large volume of water that accumulated on the top of the dishwashing unit. Employee 5 reported the machine was not to discharge water from the valve during operation and was unable to advise how long the	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 25 dishwasher valve was leaking. A subsequent observation of the dishwasher on June 6, 2023, at 12:45 PM revealed that unidentified staff were using the dishwasher to clean dishes from the lunch service. The valve on top of the dishwasher continued to leak. Staff members were unable to identify how long the dishwasher had been leaking from the valve. A review of the temperature log for the dishwasher revealed that the temperature should be measured by staff three times a day before using the machine (at breakfast, lunch, and dinner). The recommended wash cycle temperature was listed as 150 to 165 degrees Fahrenheit. The document indicated to contact the supervisor immediately if the temperatures are not correct. Review of the most recent facility documentation revealed various staff had documented the following wash temperatures below the recommended values: May 27, 2023: breakfast 140 degrees; lunch 144	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	**4702 E MAIN STREET BELLEVILLE, PA 17004**
STATE LICENSE NUMBER: **220402**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 26 degrees May 28, 2023: breakfast 142 degrees; lunch 146 degrees; dinner 145 degrees May 29, 2023: breakfast 145 degrees May 30, 2023: breakfast 140 degrees; lunch 140 degrees; dinner 148 degrees May 31, 2023: breakfast 145 degrees June 1, 2023: breakfast 140 degrees; lunch 148 degrees June 2, 2023: breakfast 149 degrees June 3, 2023, breakfast 145 degrees June 4, 2023: breakfast 140 degrees There was no evidence of any corrective action taken by staff and Employee 5 revealed that he was not aware that staff were documenting the wash temperatures below the recommended values for the dates reviewed. The above findings were reviewed in a meeting on June 8, 2023, at 2:00 PM with the Nursing Home Administrator and Director of Nursing.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 27 483.60 Food Procure, Store/Prepare/Serve - Sanitary Previously cited 06/17/2022 28 Pa. Code 211.6 (c) Dietary services	F 0812		
F 0814 SS=C		F 0814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0814 SS=C	Continued from page 28 483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. The debris surrounding the dumpster were immediately cleaned up and properly disposed of. The maintenance department were educated on proper disposal of garbage. The Director of Nutrition Services or designee will complete weekly audits	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0814 SS=C	Continued from page 29	F 0814	of the dumpster area for 4 weeks. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	**4702 E MAIN STREET BELLEVILLE, PA 17004**
STATE LICENSE NUMBER: **220402**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0814 SS=C	Continued from page 30 Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage. Findings include: Observation of the facility's main dumpster on June 6, 2023, at 10:58 AM revealed multiple pieces of broken glass, a discarded clear glove, and several small pieces of paper products on the ground surrounding the dumpster. The surveyor reviewed the above findings with Employee 5, Director of Dining Services, at the time of the findings. The above findings were also reviewed in an interview on June 8, 2023, at 2:00 PM with the Nursing Home Administrator and Director of Nursing. 28 Pa. Code: 201.18 (b)(3) Management	F 0814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0814 SS=C	Continued from page 31 28 Pa. Code 207.2 (a) Administrator's responsibility	F 0814		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 32 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Facility can not retroactively correct the deficient practice. No residents were affected by the deficient practice. Facility will develop a Water Management Program. The Water Management Program	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 33 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	will be monitored and reviewed quarterly through the Infection Control Meeting. Results of this monitoring will be reported to the Quality assurance committee to evaluate the need for ongoing development or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=E	Continued from page 34 [redacted]	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC.	4702 E MAIN STREET BELLEVILLE, PA 17004
STATE LICENSE NUMBER: 220402	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1270		P 1270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1270	Continued from page 1 § 205.39(b) Toilet room equipment. (b) Toilets used by residents shall be provided with handrails or assist bars on each side capable of sustaining a weight of 250 pounds and an emergency call bell within reaching distance. This REGULATION is not met as evidenced by:	P 1270	This Plan of Correction is submitted under Federal and state regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Assist bars were immediately added to the resident community bathroom Baseline audit of occupied rooms and community used bathrooms will occur to determine further need for assist bars. Education will be provided to the maintenance staff to educate them	Completion Date: **07/18/2023** Status: **APPROVED** Date: **06/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: **220402**	**4702 E MAIN STREET** **BELLEVILLE, PA 17004**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1270	Continued from page 2	P 1270	on the requirement to have an assist bar on each side of the toilet. Resident utilized bathrooms will have assist bars added. Random audit of resident used bathroom will be completed weekly for 4 weeks. Results of this audit will be reviewed by the Quality assurance committee to evaluate the need for ongoing auditing or further education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: 00 B. WING:	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1270	Continued from page 3 Based on observation and staff interview, it was determined that the facility failed to install an assist bar on each side of the toilet in a bathroom utilized by residents on one of six units observed (500 Hall). Findings include: Observation on June 6, 2023, at 12:07 PM revealed a bathroom on the 500 Hall located in the resident community room at the end of the unit. The bathroom was unlocked and easily accessible. The toilet contained only one set of assist bars located on the wall next to the toilet. Observation of the above bathroom on June 8, 2023, at 10:28 AM revealed the door was unlocked and partially ajar. Residents were observed in the community room and easily had access to the bathroom. An interview with Employee 8, nurse aide, on June 8, 2023, at 10:32 AM confirmed that both resident's and guests utilize the bathroom.	P 1270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395787	A. BLDG: __00_____ B. WING: _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VALLEY VIEW HAVEN, INC. STATE LICENSE NUMBER: 220402	4702 E MAIN STREET BELLEVILLE, PA 17004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1270	Continued from page 4 The above information was reviewed in a meeting on June 8, 2023, at 2:00 PM with the Nursing Home Administrator and Director of Nursing.	P 1270		

Certified End Page

VALLEY VIEW HAVEN, INC.

STATE LICENSE NUMBER: 220402

SURVEY EXIT DATE: 06/09/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY